943649348

ASSOCIATED EMPLOYERS GROUP BENEFIT PLAN & TRUST

P.O. BOX 81087 * BILLINGS, MT 59108 * PHONE 406-248-6224 * Fax 406-248-7655

Enrollment / Change Form

Employer: ~~St John's Lutheran Ministries~~ Red Lodge

Date Employed: 05/19/2015 (60 days)

Please Mark Applicable Box:
- [X] New Enrollment
- [ ] Change of Enrollment
  - [ ] Add Spouse/Dependent(s)
  - [ ] Address Change
  - [ ] Waive Employee
  - [ ] Waive Dependent(s)
  - [ ] Change to Retiree Status
  - [ ] Change Beneficiary
  - [ ] Life Only

Last Name	M.I.	Date of Birth	Date Minimum Hours Met
LeCou		07/04/1962	

First Name	M.I.	Gender	Date Coverage Effective
Karen	A	[ ] Male [X] Female	8-1-2015

Social Security Number: [redacted]

Marital Status: [ ] Single [X] Legally Married [ ] Divorced

BHJ

Current Mailing Address

Street: PO Box 193 City: Belfry State: MT Zip: 59008

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Home Phone: 509-230-3829 Work Phone: (ext.)

Life Insurance Beneficiary:	Relationship	Contingent Life Beneficiary	Relationship
Sharon Hill	Sister	Robert LeCou	Husband

Application for: Employee Only [ ] Employee & Spouse [X] Employee & Children [ ] Employee & Family [ ]

ONLY LIST DEPENDENTS BELOW IF REQUESTING COVERAGE

Last Name	First Name	M.I.	Social Security #	Gender	Date of Birth	Relationship	Do they have other Health Insurance? YES	NO	COMPANY
LeCou	Robert	M	531-84-2743	M	10/11/1976	Spouse		X	

BW not pt

Application is made for benefits under Employer's benefit plan for which I am eligible and authorization is granted to deduct from my salary or wages any premiums required. I certify the above information to be correct and true to the best of my knowledge and that those listed as dependents qualify as such under the terms of the plan.

MANDATORY: COMPLETE BOTH LEFT AND RIGHT SECTIONS

ACCEPT: If you accept coverage please complete below. (This form is valid only if completed, signed and dated.)

I elect to enroll in:
__X__ Medical _____ Dental _____ Vision

I choose the following network: (please initial one choice)

[x] HDHP ChoiceCare: 50/50 - Ded=$2600

Participants are able to use Billings Clinic physicians, clinics and hospitals only. Your primary residence must be in Yellowstone County or in an area with a zip code starting with 590

___ChoiceCare

Participants are able to use Billings Clinic physicians, clinics and hospitals only. Your primary residence must be in Yellowstone County or in an area with a zip code starting with 590.

___HDHP SelectCare

Participants are able to use the SelectCare network of physicians and clinics, both Billings Clinic Hospital and St. Vincent Hospital.

___SelectCare

Participants are able to use the SelectCare network of physicians and clinics, both Billings Clinic Hospital and St. Vincent Hospital.

I understand the health plan I chose has a provider network. If I see a *non-network provider*, charges may not be covered by the plan or I may incur a separate deductible and co-insurance maximum and be responsible for paying charges over usual and reasonable.

Signature: Kelley Schelle Date 7-13-15

WAIVER OF BENEFITS: If you decline coverage for yourself and / or your dependents, please sign and complete the following:

1. I hereby elect to waive benefits for (check applicable boxes):
   _____ Medical _____ Dental _____ Vision
   _____ Myself
   _____ My Spouse * Name _____
   _____ My Dependents * Name _____
2. Represent that (check one) [ ] I am [ ] I am not covered another plan providing medical benefits.
3. Represent that my spouse (check one) [ ] is [ ] is not [ ] Not applicable covered by another plan providing medical benefits.
4. Represent that my dependents (check one) [ ] are [ ] are not [ ] Not applicable covered by another plan providing medical benefits.
5. Represent that I am not subject to any binding court order requiring me to maintain medical expense coverage for my dependents.
6. Represent that I have received no financial or other form of inducement from my employer to make this waiver of benefits.

Signature _____ Date _____

EXHIBIT D